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STATEMENT OF

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BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

ON

THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE'S PROFESSIONAL STANDARDS REVIEW ORGANIZATION PROGRAM

HEW PSRO PPP22

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Testimony 005807

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss (1) the work we have done with respect to HEW's 1978 evaluation of the Professional Standards Review Organization (PSRO) program, and (2) our ongoing review of HEW's program for monitoring PSRO determinations of the necessity for inpatient hospital admissions and lengths of stay.

BACKGROUND

The 1972 amendments to the Social Security Act mandated the establishment of PSROs. PSROs are groups of local practicing physicians who organize and operate peer review mechanisms to assure that health care services provided under three Federal health care programs--Medicare, Medicaid, and Maternal and Child Health--conform to appropriate standards and are delivered efficiently, effectively, and economically. In addition to local groups of physicians, the Secretary of HEW can designate other suitable groups to perform PSRO review.

Among other things, PSROs review the medical necessity and appropriateness of inpatient admissions and the length of patient stays. This is generally referred to as "concurrent review." Typically, concurrent review is performed by having a PSRO review coordinator (such as a nurse) screen all patient admissions and patient lengths of stay. Cases that do not appear appropriate are referred to a PSRO physician--physician advisor--who reviews the case and makes a determination as to the medical

necessity of the patient's admission or the patient remaining in the hospital. If the PSRO physician believes that a patient does not belong in the hospital, the physician will discuss the case with the attending or admitting physician. If the PSRO physician still believes that it is not medically necessary for the patient to be hospitalized, he will issue a letter of denial, which denies payment for any additional days of care --justified on the basis of medical necessity-- by Medicare or Medicaid. PSROs must delegate the responsibility for concurrent review to hospitals that are deemed by the PSRO as capable and willing to assume such functions. These are referred to as "delegated hospitals."

As of January 29, 1979, there were 195 PSRO areas, and PSRO concurrent review was being performed--either by the PSRO or delegated hospitals--in 181 of these areas.

HEW'S 1978 PSRO EVALUATION

In June 1978 we testified before this Subcommittee on two reviews of the PSRO program that we were performing in response to requests by this Subcommittee. As part of our testimony, we discussed HEW's 1977 evaluation of the cost effectiveness of the PSRO program. We pointed out that we visited five PSRO areas and their non-PSRO comparison areas, and found that the data used by HEW in its evaluation included statistics on 20 hospitals that should not have been included in the evaluation and excluded statistics on three hospitals

which should have been included. The inclusion of inappropriate hospitals had a significant impact on the evaluation results with respect to one of the five PSROs.

Another problem we noted with the data was that it limited the identification of the Medicare eligibles to residents within the boundaries of the PSRO and comparison areas when in fact many hospitals reported that their Medicare patients reside outside of these areas.

HEW officials informed us that steps were being taken to assure that these problems were resolved prior to the use of this data in the HEW 1978 follow-on study. The follow-on study--Professional Standards Review Organization 1978 Program Evaluation--was released in January 1979. We reviewed the data used for the cost analysis part of the study and found that the data appears to have been corrected for the problem of Medicare patients receiving care in a PSRO area other than the one in which they reside. However, when we reviewed the treatment of the 23 hospitals we found that all 23 were handled the same in the 1978 follow-on study as they were in the 1977 study. Thus, HEW did not resolve the problem of inappropriate inclusion or exclusion of hospitals in its 1978 evaluation of the PSRO program.

POST-PAYMENT MONITORING PROGRAM

Regarding our review of HEW's post-payment monitoring

program we

--reviewed the activities of the Health Standards and Quality Bureau (HSQB) and the Medicare Bureau in HEW's Health Care Financing Administration (HCFA);

--reviewed the activities of six PSROs in Massachusetts, South Carolina, Ohio, California, and Nevada; and

--visited seven hospitals in Massachusetts and two hospitals in California.

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Under HEW's post-payment monitoring program, Medicare fiscal intermediaries, such as Blue Cross and Aetna, sample PSRO determinations of the necessity of inpatient hospital care. The monitoring program has two objectives: (1) to insure the flow of information among intermediaries and PSROs with respect to new techniques of concurrent review, medical management, and quality assurance, and (2) to develop information to assist the Secretary of HEW in determining the efficiency, effectiveness, and progress of each PSRO conducting concurrent review. According to the Office of Planning, Evaluation and Legislation of HEW's Health Services Administration, the cost of a fully implemented nationwide post-payment monitoring system has been estimated at $9 million annually.

Medicare fiscal intermediaries are required to review a 20-percent sample of all inpatient hospital claims reviewed by a PSRO. After completing their review, the intermediaries prepare summary reports which identify hospital claims which the intermediaries found questionable but which had been approved by the PSROs. These reports are shared with the PSRO and the regional HSQB offices.

Our analysis of Medicare intermediary post-payment monitoring reports showed that the intermediaries' physicians were questioning PSRO determinations in the areas of (1) hospital admissions for diagnostic tests which could have been performed on an outpatient basis and (2) delays in discharging patients. These reports identify the hospitals, case numbers, and patient days, and include an explanation of why intermediary physicians believed the hospitalizations or delayed discharges were unnecessary and should have been denied. Most reports also indicate the extent to which the PSROs agreed with the fiscal intermediary physicians.

For the six PSROs included in our review, we attempted to estimate the total number of days the intermediaries would have questioned had they reviewed all claims (rather than just 20 percent of the claims) by using the intermediary sampling data and multiplying the number of days sampled and the sampling results--both for the total days questioned and the number of days with which the PSRO agreed--by 5.

We did this for only three of the six PSROs included in our review because

--the fiscal intermediary for the Nevada PSRO did not have information readily available on the number of days in the sample; therefore, rather than projecting the number of Medicare days subject to being sampled, we used the number of days certified by the PSRO as the size of the universe; and

--the other two fiscal intermediaries--which reviewed the Cincinnati, Ohio, area and California Area XXIII PSROs--did not use random sampling techniques; therefore, their sampling results could not be projected.

As shown in the following chart, the fiscal intermediaries questioned from 1.1 to 5.5 percent of the days of care that the PSROs had certified as necessary. Moreover, the PSROs agreed that between .2 and 4.2 percent of the days that they certified as necessary, were unnecessary.

A 1 or 2 percent reduction in hospital utilization can be an important factor. HEW has said that 96 PSROs that reduced Medicare hospital utilization by an average of 1.5 percent were cost effective. On the other hand, we were told by a Congressional Budget Office (CBO) official that information reviewed by CBO indicates that a PSRO becomes cost effective when hospital utilization is reduced by 2.9 percent.

PSRO	Total Medicare days subject to sample	Fiscal Intermediary Questioned Days		Questioned Days tha PSRO Agreed With	
		Number	Percent of total days sampled	Number	Percent of tota days sampled
Bay State, Mass.	573,080	6,370	1.1	1,230 (note a)	.2
Charles River, Mass.	55,350	3,060	5.5	1,460	2.6
South Carolina	292,040	5,385	1.8	1,795	.6
Nevada	105,122	5,485	5.2	4,415	4.2
Totals	1,025,592	20,300	2.0	8,900	.9

a/This PSRO did not indicate the extent to which it agreed with the intermediary's determinations. We had PSRO physician advisors review a 20 percent sample of the days questioned by the fiscal intermediary to project this number.

In addition, although we were unable to determine the extent to which unnecessary diagnostic admissions and delayed discharges exist in the two other PSRO areas that we reviewed, we were able to confirm that these problems also occurred in these areas. For example, Blue Cross of Southern Ohio sampled 14,589 patient days in 22 hospitals in the Cincinnati, Ohio, PSRO area during 1977. Blue Cross reported--and PSRO officials and physicians agreed--that 371 of the 14,589 patient days (or about 2.5 percent) were unnecessary diagnostic admission or delayed discharge days.

Blue Cross of Southern California and Aetna, for the period July 1977 through June 1978, issued 28 reports on 28 California PSRO Area XXIII hospitals. Blue Cross reports questioned 657 patient days as unnecessary diagnostic admissions and delayed discharges. The PSRO agreed that 129 of the 657 patient days were unnecessary.

We discussed the possible causes for these unnecessary diagnostic admissions and delays in discharges with PSRO officials, and were informed of several factors which appear to have contributed to the problem.

Five of the six PSROs had, in most instances, delegated their patient review authority to the hospitals in their respective areas. The executive directors of three of the five PSROs said that utilization review personnel at delegated hospitals had not been adequately monitored by the PSROs. In addition, one of the three PSROs did not make regular visits to the hospitals.

Reluctance of PSRO personnel to enforce guidelines is another factor given as a cause for unnecessary diagnostic admissions and delays in discharges. PSRO officials at the six PSROs included in our review said that hospital

utilization review personnel are sometimes reluctant to challenge an admitting or attending physician's judgment on medical necessity. We were advised by four PSRO physicians and officials from three PSROs that some physician advisors were unfamiliar with Medicare regulations and instructions.

We were also informed that because PSRO review is performed at certain times during a patient's stay, patients may needlessly remain in the hospital from the date that they are ready for discharge until the next date PSRO review is performed. Under the PSRO review system, the admittance of Medicare patients to a hospital is generally reviewed by a PSRO coordinator, usually a nurse, and if necessary, a physician advisor. If the admission is certified as necessary, the coordinator assigns the patient a length of stay, that is, the number of hospital days that patients historically need before being discharged for a particular illness or operation. In addition

to the initial review, the patient is reviewed at the end of the assigned length of stay and periodically thereafter. Officials at two PSROs said that many of the unnecessary days were certified as necessary between the initial review and the assigned length of stay checkpoint, that is, some people are ready for discharge before the second review takes place but are not discharged until the coordinator reviews the case.

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I have summarized the efforts of the HEW fiscal intermediaries' monitoring of the six PSRO areas included in our review and some of the factors which appear to have contributed to PSROs certifying unnecessary days of care. As can be seen, fiscal intermediaries are questioning from 1.1 to 5.5 percent of the days of care that the PSROs are certifying as necessary. I would like now to discuss some areas where we believe HCFA should improve its oversight of the PSRO post-payment monitoring program.

HCFA OVERSIGHT OF PROGRAM

As previously stated, the post-payment monitoring program can be used to identify Medicare patient days of care that could be saved by eliminating unnecessary diagnostic admissions and delays in discharging Medicare patients.

HCFA officials informed us that the post-payment monitoring program should, among other things, serve as an educational experience for PSRO review coordinators, PSRO physician advisors, and for admitting and attending physicians. By reviewing and discussing the cases questioned by the fiscal intermediaries, PSRO review coordinators and physicians should be able to learn additional techniques for identifying days of care that are not necessary. In addition, admitting and attending physicians should be made aware of cases where their decisions to admit or to keep patients in the hospital were being questioned, and the reasons why they were questioned. The admitting and attending physicians are supposed to consider this information when making future decisions.

We believe that HCFA could provide better guidance to PSRO program personnel, PSROs and physicians to insure that the post-payment monitoring program is operating as HCFA intends. We believe the overall effectiveness of the program could be enhanced if HCFA

--provided specific guidance and instructions regarding the actions PSROs are to take as a result of the reports prepared by the fiscal intermediaries, and

--insured that the data collected and included in the fiscal intermediary reports were appropriate to meet program needs.

PSRO Actions on Intermidiary Reports

HCFA has prepared instructions on how fiscal intermediaries are to develop and prepare their post-payment monitoring reports. However, no guidelines or instructions have been issued regarding how the reports are to be used in meeting the objectives of the post payment monitoring program. HSQB officials stated that no formal guidelines or instructions were issued because they believed oral instructions were sufficient.

HCFA officials informed us that they have not issued instructions requiring that PSROs respond to the fiscal intermediaries reports. They did however, expect that the PSROs would respond. During the early stages of our review, we learned that many PSROs were not responding to these reports. In May 1978, we contacted HEW's ten regional Medicare offices and learned that 46 of the then 154 PSROs conducting concurrent reviews, were not responding to intermediary reports. During the past year many of these 46 PSROs have started to respond. In May 1979 we again contacted HEW's regional Medicare offices and were informed that only six of the 183 PSROs now conducting current reviews were not responding to the intermediary reports.

At three of the six PSROs we visited--Bay State, Medco Peer Review, and Nevada--we learned that PSRO physicians

were not routinely using fiscal intermediaries post-payment monitoring reports as a means of sharing concurrent review techniques and experiences.

These three PSRO's did not routinely discuss fiscal intermediary monitoring results with their physician advisors, with the delegated hospital utilization review committees or with the attending or admitting physicians in the questioned cases. Also, few PSRO physician advisors in five of the six PSROs regularly met face to face with fiscal intermediary physicians to discuss questioned cases.

Data Collected and Reported by Fiscal Intermediaries

Medicare officials informed us that the system for collecting and reporting post-payment monitoring data was designed before it was fully known what type of data could be produced or how the data would be used. As a result, certain data which is needed by the program in order to meet its objectives is not being collected, and certain data is being collected which, at present, is not being used by HSQB.

Post-payment monitoring reports deal primarily with claims data. For example, the reports indicate the number of Medicare claims a hospital submitted in a month, the number of claims sampled and questioned, and the number of patient days in the questioned claims. However, the guidelines for preparing the reports do not indicate that the total number of patient

days in the sample should be reported. Thus, the data is sufficient to indicate if a problem exists, but is insufficient to define the magnitude of the problem. In order for us to establish the extent of the problem at two of the four PSROs shown on the chart, we had to in one case obtain information on the number of patient days sampled from the fiscal intermediary and in a second case use the number of days certified by the PSRO, as being the size of the universe. The fiscal intermediaries for the other two PSROs reported the number of days in the sample even though this information was not called for by the guidelines.

We also found certain cases where data was being collected but not used. For example, PSRO and fiscal intermediary physicians often disagreed on the need for certain Medicare patients to be in the hospital. In South Carolina PSRO physicians disagreed with fiscal intermediary physicians on 67 percent of the patient days questioned for diagnostic admission or delayed discharge. Under the post-payment monitoring system, statistics on these disagreements and synopses of the medical records are collected by the fiscal intermediaries and the Medicare Bureau and provided to HSQB. HSQB officials advised us that they have yet to determine how to use this information.

CONCLUSIONS

We believe that if effectively used, the post payment

monitoring program could be a helpful tool to HEW and PSRO management in obtaining reductions in unnecessary Medicare utilization by identifying areas where PSRO review activities can be improved. Recent analyses by HEW and CBO indicate reducing hospital utilization by 1.5 or 2.9 percent respectively, results in PSRO concurrent review being cost effective. At the four PSROs where we were able to relate intermediary findings to total Medicare days, we determined that fiscal intermediaries questioned from 1 to over 5 percent of the Medicare days that they reviewed as being unnecessary, because patients were admitted for diagnostic work which could have been performed on an outpatient basis, or because the patients were kept in the hospital longer than necessary. The days questioned were days that the PSRO had certified as necessary.

Further officials at two of the four PSROs, agreed that they had inappropriately certified about 2.6 and 4.2 percent of the total days sampled. Thus, it appears that if effectively used, the post-payment monitoring program offers the potential to improve the overall performance of individual PSROs by identifying areas where unnecessary utilization can be eliminated.

We believe, however, that the effectiveness of the post-payment monitoring program could be enhanced if HCFA (1) provided specific instructions to PSRO program personnel, PSROs, and physicians on how the fiscal intermediary reports are to be used and (2) insured that the data collected and reported by the fiscal intermediaries were appropriate to meet program needs.

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Mr. Chairman, this concludes our statement. We would be pleased to answer any questions you or any other Members of the Subcommittee may have.